EDMUND G. BROWN JR.
Attorney General of California
FRANK H. PACOE
Supervising Deputy Attorney General
HANNAH H. ROSE
Deputy Attorney General
State Bar No. 56276
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5515
Facsimile: (415) 703-5480
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **PATRICIA QUINN-DAY** **P.O. Box 236** **Lockwood, CA 93932** **Registered Nurse License No. 470247** Respondent.	Case No. 2010-21 **ACCUSATION**

Complainant alleges:

PARTIES

1. Heidi J. Goodman (Complainant) brings this Accusation solely in her official capacity as the Assistant Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 31, 1991, the Board of Registered Nursing issued Registered Nurse License Number 470247 to Patricia Quinn-Day (Respondent). The Registered Nurse License expired on January 31, 2007, and has not been renewed.

//

//

//

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it.

7. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

//

8. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

9. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

10. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct/Gross Negligence)

11. Respondent is subject to disciplinary action under section 2761 (a) (1), in that on or about September 13, 2005, September 22, 2005, September 26, 2005 and January 25, 2006, while employed as a registered nurse in the Neonatal Intensive Care Unit (NICU) at Salinas Valley Memorial Healthcare System (SVMHS), she repeatedly documented in patients' charts nursing care, including assessment data and interventions which were never done, and she failed to apply basic safety precautions to safeguard the patients' well-being. The circumstances are as follows:

12. On or about September 13, 2005, while under observation at the NICU at SVMHS, at approximately 1500 hours, Respondent undertook to care for and treat two clients, Patient C and Patient D. Respondent documented that she had made a full assessment of Patient C at 1546 hours and also documented that she had made a full assessment of Patient D at 1541 hours. There was insufficient time after the assessment of Patient D to have competently assessed Patient C. She was observed to have assessed only one patient, but to have documented the assessment of two patients at or about that time.

13. On or about September 22, 2005, while under observation at the NICU at SVMHS, at approximately 1539 hours, Respondent was observed assessing Patient F-1 and entering the information into the computer. She was also observed entering into the computer that she had assessed Patient F at 1544 hours. While being observed, she was not seen to have assessed

Patient F, and there was not enough time between patients to have performed a competent assessment of Patient F.

14. On or about September 26, 2005, while under observation at the NICU at SVMHS, at approximately 1535 hours, Respondent was observed not completing auscultation for breath and heart, or taking the temperature of Patient B, but was observed entering the information into the computer at 1535 hours. It was also observed that Respondent did not do a visual or any other assessment of the patient before entering documentation into the computer.

15. On or about September 26, 2005, while under observation at the NICU at SVMHS, at approximately 1548 hours, it was observed that Respondent did not do a visual or physical assessment of Patient E before she entered documentation of an assessment of Patient E into the computer.

16. On or about January 25, 2006, while under observation at the NICU at SVMHS, at approximately 1549 hours, it was observed that Respondent did not perform an assessment of Patient A before she entered documentation of an assessment of Patient A into the computer.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct/Incompetence)

17. Respondent is subject to disciplinary action under section 2761 (a) (1), in that on or about September 13, 2005, September 22, 2005, September 26, 2005 and January 25, 2006, while employed as a registered nurse in the NICU at SVMHS, Respondent repeatedly failed to comply with the Scope of Regulations for the Practice of Nursing according to the Policies and Protocols that had been developed at SVMHS when she did not perform assessments of assigned patients whom she documented as having assessed as set forth in paragraphs 12 through 16 above.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct/Incompetence)

18. Respondent is subject to disciplinary action under section 2761 (a) (1), in that on or about January 11, 2006, while employed as a registered nurse in the Neonatal Intensive Care Unit

at SVMHS, she failed to comply with the Policy and Protocols of the SVMHS regarding the dispensing of expressed breast milk. After the incident she failed to document acknowledgement of the incident as required by the SVMHS NICU Policy and Procedure on Breast Milk Storage. The circumstances are as follows:

19. On or about January 11, 2006, Respondent gave the wrong breast milk to Patient G-2 when she fed the patient breast milk from Patient G-1. Patient G-1 had expressed breast milk for her own infant who was a patient at SVMHS NICU. Patient G-2 was not the child of Patient G-1. Respondent failed to follow the Policy and Procedure requirement for verification by two licensed nurses that the label on the bottle correspond with the patient's ID band before feeding expressed breast milk to an infant. It was also required that if an infant received breast milk from anyone other than their mother, that the event must be "treated as a body fluid exposure" which required the completion of a Quality Review Report and managed according to the Infection Control Policy. Respondent failed to document the event as required.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct/Incompetence)

20. Respondent is subject to disciplinary action under section 2761 (a) (1), in that on or about September 13, 2005, September 22, 2005, September 26, 2005 and January 26, 2006, while employed as a registered nurse in the NICU at SVMHS she repeatedly failed to exercise the implementation of Nursing Process, which includes observation of the client's physical condition and behavior for the purpose of formulating a nursing diagnosis as set forth above in paragraphs 12 through 16 above.

//

//

//

//

//

//

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 470247, issued to Patricia Quinn-Day Patricia Quinn-Day.

2. Ordering Patricia Quinn-Day to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 7/20/09

HEIDI J. GOODMAN
Assistant Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SF2008200940
accusation.rtf